STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
			-				
		005051	B. WING		11/14/2014		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
INDIANA I	INDIANA UNIVERSITY HEALTH  1701 N SENATE BLVD  INDIANAPOLIS, IN 46202						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
S 000	INITIAL COMMENTS		S 000				
	This is a hospital licer investigation.						
	Date of Survey : 11/14						
	Facility Number : 005						
	Complaint # IN001555 Substantiated: State of allegations are cited.	282 deficiencies related to the					
	Surveyors : Albert Da	aeger, Medical Surveyor					
	QA Review: JLee 01-	20-15					
S 610	410 IAC 15-1.5-2 INF	ECTION CONTROL	S 610		3/11/15		
	410 IAC 15-1.5-2(f)(3)(D)(x)						
	(f) The hospital shall einfection control command guide the infection program in the facility (3) The infection control responsibilities shall in not be limited to, the f (D) Reviewing and rein procedures, policie which are pertinent to control. These includ limited to, the followin (x) A program of food and storage for all per in food handling which is not limited to, the followin (AA) Storage of employed.	nittee to monitor n control as follows: rol committee nclude, but following: commending changes s, and programs infection e, but are not g: d preparation rsonnel involved in includes, but following:					
	(AA) Storage of employation refrigerators.	oyee 1000 iii					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
	005051		B. WING		11/14/2014		
INDIANA UNIVERSITY HEALTH 1701 N SEN			DRESS, CITY, STATE, ZIP CODE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S 610	Continued From page	: 1	S 610				
	(BB) Medications in n refrigerators.  (CC) Refrigerator and temperature monitoring	freezer					
	This RULE is not met as evidenced by: Based on document review, observation, and staff interview, the facility failed to ensure IU Health Riley offsite Main Kitchen refrigeration storage units were complying with basic sanitation practices specified in 410 IAC 7-24, Retail Food Establishment Sanitation Requirements effective November 13, 2004 and hospital policies						
	5.20, Labeling and Da 1/22/13). The policy clearly marked to indi date. Food items pre storage period and rebeen open and stored a 7-day storage periodiscarded; all food sh	follow their policy/procedure ate Marking (Last approved indicated food items shall be cate the use by or expiration pared onsite have a 3 days ady-to-eat food that has d in the refrigerated unit has d before it has to be used or all be covered or in closed against the possibility of					
	Packaging, and Segre indicated Food shall to contamination by the	packaged Food; Separation, egation, 410 IAC 7-24-173 be protected from cross following: Separating raw					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
		005051	B. WING		11,	/14/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
INDIANA	UNIVERSITY HEALTH		NATE BLVD				
(VA) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES	OLIS, IN 46202	PROVIDER'S PLAN OF COR	PRECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
S 610	Continued From page	e 2	S 610				
	are washed during st	orage, preparation un					
	3. At 10:50 AM on 11/14/2014, the Indiana University Health Riley offsite main kitchen's walk-in cooler was toured. Cases of unwashed assorted produce were observed on racks directly above pre-packaged ready-to-eat produce and a package soup. An upright cart containing sheets of bacon for further cooking were observed not covered to protect again environmental contamination. On the storage rack were assorted opened packages of salami and other deli meet that were plastic wrapped and were not date marked with the date they were either first opened or the date they were to be discarded if not used within that period. A container of ready-to-eat meatballs was not date marked as required by hospital policy. Open container of potato salad that was plastic wrapped after used was observed with heavy excess of potato salad residue smeared over the plastic and on the container itself.						
	Main kitchen was tou ready-to eat scramble observed not covered the required 7-day cu	iversity Health Riley offsite red. A container of left-over ed egg omelets were d or date marked reflecting mulative refrigeration of assorted food products					
	(Foodservice Operati walk-in cooler needed were several items th marked as per hospit confirmed the sanitati lacking cleanliness.	1/14/2014, staff member #4 ons Manager) confirmed the d organization and there lat were not properly date al policy. The staff member ion in the walk-in cooler was Cases of food product in the stored to high on the food					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		005051	B. WING		11/14/2014		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
INDIANA I	JNIVERSITY HEALTH		SENATE BLVD				
0/0.15	SHIMMADV ST	ATEMENT OF DEFICIENCIES	APOLIS, IN 46202	PROVIDER'S PLAN OF CORRECTION	N OVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
S 610	Continued From page	3	S 610				
	18-inch minimum dist product to the walk-in product was too close the walk-in cooler. Th the walk-in cooler was	the product was exceeding ance allowed from the cooler ceiling; however, the e to the sprinkler heads in his over-stocked of food in a contributed to the other ents in Riley's offsite storing e cooler.					
S1118	410 IAC 15-1.5-8 PH	YSICAL PLANT	S1118		3/11/15		
	410 IAC 15-1.5-8 (b)(	2)					
	<ul> <li>(b) The condition of the plant and the overall be environment shall be maintained in such a safety and well-being assured as follows:</li> <li>(2) No condition shall maintained which may hazard to patients, put employees.</li> </ul>	nospital developed and manner that the of patients are  I be created or y result in a					
	This RULE is not me Based on document r staff interview, the fac hospital environment safety and well-being staff are assured for t Riley offsite main kitch	eview, observation, and cility failed to maintain the in such a manner that the of patients, visitors, and/or he Indiana University Health					
	Findings included:						
	18-inch clearance for Storage that is too clo	ife Safety Code requires a each sprinkle head. se to a sprinkler pendant patterns, thus the 18-inch					

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	COMPLETED	
	005051	B. WING		11.	/14/2014	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE			
INDIANA UNIVERSITY USALTU	1701 N SI	ENATE BLVD				
INDIANA UNIVERSITY HEALTH	INDIANA	POLIS, IN 46202				
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	COMPLETE DATE	
S1118 Continued From page	4	S1118				
	ture and the mandad to					
clearance requirement						
	pray from the sprinkler in					
case it was activated of	due to a fire emergency.					
2. Dovious of policy/pr	acadura E 6 Nutrition 9					
	ocedure 5.6 Nutrition & ed 5/6/13); the HACCP					
	ng and Storage of Products					
I	dicated proper storage of					
	eserve its quality, prevent					
	ard bacterial growth. The					
I	d storage areas will be kept					
1 ' -	I times. Food will be stored					
at least 6 inches above						
	under the storage crates.					
Foods not subject to fu	Foods not subject to further washing or cooking					
will be protected from	will be protected from contamination by foods					
requiring further washi	requiring further washing or cooking. All food					
shall be covered or in	closed containers to protect					
against the possibility	of contamination.					
3. At 10:30 AM on 11/	/14/2014, the Indiana					
University Health Riley	offsite main kitchen was					
toured. The floor was	observed with spilt case of					
blue berries lying on th	ne floor. The berries were					
covering the aisle of the	ne walk-in cooler and were					
observed lying under t	he food storage rack loose					
	oose melons and a corn					
cob were observed lying	_					
· ·	sorted food products that					
	op of the wire racked shelf					
I	inches from the ceiling.					
I	d a sprinkler head that was					
1	of the stacked cases on the					
<u> </u>	on the racks in the walk-in					
	disorganized. Another row					
of assorted cases of fo						
<u> </u>	n the storage rack of food					
	4 inch high plastic crates.					
This extended row was	s also obstructing the the walk-in freezer. Under					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	005051		B. WING		11/14/2014	
		1701 N SEN	IATE BLVD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S1118	PROVIDER OR SUPPLIER  UNIVERSITY HEALTH  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		S1118			

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